

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 6, See Birth Cert. et

13716

13726

332

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Delaware</i>		b. COUNTY <i>Sussex</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN lb <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		d. STREET ADDRESS <i>103 West Eight Street</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>Richard</i>	Middle <i>Spencer</i>	Last <i>Barr</i>	4. DATE OF DEATH <i>December 14 - 1957</i>	Month <i>Dec</i>	Day <i>14</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/9/57</i>	9. AGE (In years lost birthday) <i>5 days</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. FATHER'S NAME <i>William S. Barr</i>		
13. MOTHER'S MAIDEN NAME <i>Vera Clarke</i>		14. MOTHER'S MAIDEN NAME <i>Vera Clarke</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>William S. Barr, Funeral Dir.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congenital Cyanotic Heart Disease</i>		DUE TO <i>Patent Ductus Arteriosus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i>				
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Blindly Ending Aorta</i>		DUE TO <i>Inter-ventricular Digital defect; Patent foramen ovale</i>						
DUE TO <i>Functionally a Truncus Arteriosus</i>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Laurel</i>		(County) <i>Laurel</i>		(State) <i>Del</i>
21. I certify that I attended the deceased from <i>12/9</i> , 1957, to <i>12/14</i> , 1957, that I last saw the deceased alive on <i>12/14</i> , 1957, and that death occurred at <i>Laurel</i> , M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Laurel, Del.</i>		DATE SIGNED <i>12/14/57</i>		
ACTUAL SIGNATURE <i>Alfred C. Kolls</i>		PHYSICIAN'S NAME (Type) <i>M.D.</i>		Medical Center Salisbury, Md		<i>12/14/57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/16/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Old Christ Ch. Cemetery</i>		22d. LOCATION (City, town, or county) <i>Laurel</i>		(State) <i>Del</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Holloway Laurel Del.</i>		ADDRESS <i>103 West Eight Street Laurel Del.</i>		24a. REC'D BY REGISTRAR DATE <i>Dec 18 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		
2082313XV5								

CERTIFICATE OF DEATH

HANSON

BUREAU V. S.

DEC 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13717

## CERTIFICATE OF DEATH

Reg. Dist. No.

1372337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Hebron</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		d. STREET ADDRESS <b>Railroad Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ERNEST MC CREADY BENNETT</b>		First <b>ERNEST</b>	Middle <b>MC CREADY</b>	Last <b>BENNETT</b>	4. DATE OF DEATH <b>DECEMBER 4 th 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1886</b>	9. AGE (In years last birthday) yrs. <b>71</b>	10. IF UNDER 1 YEAR Months <b>10</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee Wayne Pump Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>Mardela, Maryland</b>	
13. FATHER'S NAME <b>Ebenezer T. Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Phillips</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-6300</b>		17. INFORMANT Mrs. Olive R. Bennett (Wife) Railroad Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for, (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5870</b>		DUE TO <b>Acute Pancreatitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>22 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-10</b> , 19 <b>55</b> , to <b>12-4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12-4</b> , 19 <b>57</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Earl Royer</b>		M.D.		ADDRESS (Street, city or town, state) <b>Camden Ave. Salisbury, Maryland</b> DATE SIGNED <b>Dec. 5 / 57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 6. 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mardela Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Mardela, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 9 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V.E.**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13728932

Reg. Dist. No.

## CERTIFICATE OF DEATH

13718

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b -----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>		d. STREET ADDRESS <b>2nd and Cedar Streets</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>In route to Peninsula General Hosp.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>ALMA</b>	Middle <b>H.</b>	Last <b>BLAINE</b>	4. DATE OF DEATH <b>December</b>	Month <b>21,</b>	Day <b>1957</b>	Year	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James P. Blaine</b>				14. MOTHER'S MAIDEN NAME <b>Mollie A. Hargis</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)	16. SOCIAL SECURITY NO. <b>216-38-9180</b>	17. INFORMANT <b>Mrs Ida Scott, Pocomoke City, Maryland</b>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b>								
DUE TO (b) <b>ACUTE MYOCARDIAL INFARCTION</b>								
DUE TO (c) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b>								
INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Pocomoke City</b>	(County) <b>Worcester</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>12-21</b> , 1957, to <b>12-21</b> , 1957, that I last saw the deceased alive on <b>12-21</b> , 1957, and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>C. Stanford Hamilton</i>	ADDRESS (Street, city or town, state) <b>Pocomoke City, Md. 12/21/57</b>							DATE SIGNED
PHYSICIAN'S NAME (Type) <b>C. STANFORD HAMILTON</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-23-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Presbyterian Cemetery</b>			22d. LOCATION (City, town, or county) <b>Pocomoke City, Maryland</b>			(State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry J. Watson</i>		ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 2019</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Bellows</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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WISCONSIN STATE DEPARTMENT OF HEALTH - BAZTOMORE

CERTIFICATE OF DEATH

BUREAU V.

DEC 27 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13762 CERTIFICATE OF DEATH										13733 ✓		
1. PLACE OF DEATH o. COUNTY <b>Wicomico</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b>					Reg. Dist. No.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron - Rural</b>					c. LENGTH OF STAY IN 1b <b>30 years</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X1 Hebron - Rural</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Quantico Road</b>					d. STREET ADDRESS <b>Quantico Road</b>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Ollie</b>	Middle <b>Ellen</b>	Last <b>Burris</b>	4. DATE OF DEATH <b>December 13 1957</b>	Month Day Year						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1907</b>			9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			11. BIRTHPLACE (State or foreign country) <b>Somerset Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Edgar Jones</b>					14. MOTHER'S MAIDEN NAME <b>Julia White</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>219-05-3746</b>			17. INFORMANT <b>Lonnie F. Burris, Hebron, Md., R.F.D.</b>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260X</b> DUE TO Diabetes Mellitus											INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY Month, Day, Year Hour p. m. 19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from <b>Dec. 1, 1955</b> , to <b>Dec. 13, 1957</b> , that I last saw the deceased alive on <b>Dec. 9, 1957</b> , and that death occurred at <b>2:30A.M.</b> from the causes and on the date stated above.											ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>	DATE SIGNED <b>12/14/57</b>
ACTUAL SIGNATURE <b>G. Herbert Sembley</b>											PHYSICIAN'S NAME (Type) <b>G. Herbert Sembley</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 15, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Zion Church Cemetery</b>			22d. LOCATION (City, town, or county) <b>Quantico, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>					ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>			24a. REC'D BY REGISTRAR <b>DEC 18 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary H. Hollaway</b>			

## INDIANA STATE GOVERNMENT

## CERTIFICATE OF DEATH

State of Indiana  
County of Marion

Date of Birth

Cause of Death

Place of Death

Name of Hospital

Name of Doctor

Name of Mortician

Name of Cemetery

Name of Coroner

Name of Sheriff

Name of Clerk

Name of Sheriff's Deputies

BUREAU V. S.

DEC 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13719

## CERTIFICATE OF DEATH

13730  
372

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MICOMICO</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN lb <b>YEAR</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY 12</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ARCHIE</b>	Middle <b>CORNISH</b>	Last <b>CORNISH</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>2</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>??</b>	9. AGE (in years lost birthday) <b>64 YEARS</b>	10. UNDER 1 YEAR Months <b>6</b>	11. UNDER 24 HRS. Days <b>4</b>	12. HOURS Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BLIND</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL CORNISH</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA BYRD</b>		Address <b>DOROTHY CORNISH PRINCESS ANNE MD. RFD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>Indefinite</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o.m. p.m.,	Month 19	Day White at work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED M.D.	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>652 W main St</b>	20f. (City or town) <b>Salisbury, Md.</b>	(County) <b>Wicomico Co.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>20ct</b> , 19 <b>57</b> , to <b>28ce</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>20ct 10</b> , 19 <b>57</b> , and that death occurred at <b>10</b> M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>E. A. Purcell</b> ADDRESS (Street, city or town, state) <b>652 W main St</b> DATE SIGNED <b>6 Dec 57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12/7/57</b>		22b. DATE THEREOF <b>12/7/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>McLean</b>	22d. LOCATION (City, town, or county) <b>Talbot Road Maryland</b>	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. James Jr., Princess Anne, Md.</b>		ADDRESS <b>12/7/57</b>	24a. REC'D BY REGISTRAR <b>Mary W. Holloway</b>	24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>			

AMERICAN CIGARETTE & SULFURIC ACID  
MANUFACTURING COMPANY

RECEIPT OF DEATH

CHARTER

BUREAU V. 8

DEC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13720 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

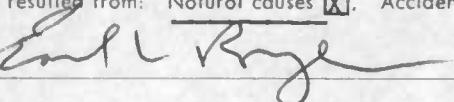
13731

Reg. Dist. No.

**FOR STATE  
HEALTH DEPT.**

**NO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

**NO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
Wicomico MARYLAND				b. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Salisbury		life		Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM?			
Peninsula General Hospital				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day
John Simpson Coulter		3rd		12-	8-	19	57
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH	9. AGE (In years from birthday)	10. IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 2, 1957	0 yrs.	Months 32	Days 6	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
infant		None		Maryland-Salisbury Hosp.		U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Simpson Coulter Jr				Irene Beatrice Wilkerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT			
No				Mr. John S. Coulter (Father) Address Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute laryngo-tracheo-bronchitis 500X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 				DATE SIGNED 12-10-57			
EXAMINER'S NAME (Type)		Earl L. Royer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park		22d. LOCATION (City, town, or county) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.				24a. REC'D. BY REGISTRAR DEC 11 1957		24b. REGISTRAR'S SIGNATURE Mary J. Holloway	
2082252 XV4							

RECEIVED  
FBI BUREAU NEW YORK

DEC 11 1957

Intelligence Information

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13721

## CERTIFICATE OF DEATH

(13732)

Reg. Dist. No.

13732

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WICOMICO</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saint Lucie</i>		c. LENGTH OF STAY IN 1b <i>WR</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XI Salisbury</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>JERSEY RD. #2</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	BRIAN <i>Douglas</i>	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX	MALE	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>1/2/1955</i>	9. AGE (In years less birthday) 2 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Baby</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>ROBERT L. CULVER, SR</i>	14. MOTHER'S MAIDEN NAME <i>Ruth CHAFFEY</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>ROBERT L. CULVER, Sr. SAME.</i>	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>092X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			<i>Auto Hepatic Failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Leukemia, acute lymphocytic</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> off work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Salisbury</i>	(County)	(State)		
21. I certify that I attended the deceased from <i>Dec 7</i> , 1957 to <i>Dec 14</i> , 1957, that I last saw the deceased alive on <i>Dec 14</i> , 1957, and that death occurred at <i>165</i> M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Robert W. Saunders Jr.</i>								
ADDRESS (Street, city or town, state) <i>976 N Division St. Salisbury Md.</i>								
DATE SIGNED <i>12/14/57</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL 12/17/1957</i>		22b. DATE THEREOF <i>12/17/1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>PARSONS CEMETERY</i>		22d. LOCATION (City, town, or county) <i>SALISBURY, MARYLAND</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hill Johnson &amp; Sons, Salisbury, Md.</i>				ADDRESS <i>Norman F. Baker</i>		24a. REC'D BY REGISTRAR <i>12-10-67</i>		
						24b. REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC SAFETY - DIVISION OF POLICE

BUREAU V. S.

DEC 19 1957

RECEIVED

1

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. ATSM  
5M 2/57

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**13733**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13763

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13733  
332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		c. LENGTH OF STAY IN 1b <b>3 mo.</b>		d. STREET ADDRESS <b>XO Hebron</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R F D # 1</b>				R F D # 1					
3. NAME OF DECEASED (Type or print) <b>Mamie X</b>		First	Middle	Last	4. DATE OF DEATH <b>Curtis</b>	Month <b>12-</b>	Doy <b>12-</b>	Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1888</b>	9. AGE (In years from birthday) <b>69 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>			IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Jeannie Newcomb</b> Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT <b>Husband: Elmer Curtis Hebron, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>Stutter</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Congestive Heart Failure</b> hours. (c) <b>Atherosclerotic Heart Disease</b> you									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12-12-57</b>							
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>12-13-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lewis R. Wilson</b> ADDRESS <b>Princess Anne, Md.</b> 461-171937 DATE 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>									

BUREAU U.S.

DEC 17 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 Royer

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 337	13734	
13722 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			c. LENGTH OF STAY IN 1b <i>6 mo</i>			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>			e. STREET ADDRESS <i>512 Tongue St.</i>			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Alvwood S Doshill</i>			First	Middle	Last	4. DATE OF DEATH <i>12-1-1957</i>	Month	Day	Year			
5. SEX <i>m</i>	6. COLOR OR RACE <i>c</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1894</i>			9. AGE (In years last birthday) yrs. <i>63</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. IF UNDER 24 HRS. Min. <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			11. BIRTHPLACE (State or foreign country) <i>James Island Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>					
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>?</i>			17. INFORMANT <i>Willie Doshill - 512 Tongue St</i>	Address <i>512 Tongue St</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>										INTERVAL BETWEEN ONSET AND DEATH <i>yr.</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>			
21. I certify that I attended the deceased from <i>11-22</i> , 19 <i>57</i> , to <i>12-1</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11-30</i> , 19 <i>57</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Earl Royer</i> M.D. PHYSICIAN'S NAME (Type) <i>Earl L Royer</i>										ADDRESS (Street, city or town, state) <i>407 Camden Ave</i>	DATE SIGNED <i>12-4-57</i>	
22a. BURIAL, CREMATION, DECOMPOSITION (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-6-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Green Acres Cem</i>		22d. LOCATION (City, town, or county) <i>Salisbury</i>		(State) <i>Wicomico</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. W. Leach</i>					24a. REC'D BY REGISTRAR DATE <i>DEC 9 1957</i>							
					24b. REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>							

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 9 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13735

13764

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>		d. STREET ADDRESS <b>X2 Mardela</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Georgia</b>	Middle <b>Anna</b>	Last <b>Dashiell</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>17</b>	Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 28, 1893</b>	9. AGE (In years lost birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Accomack, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Thomas Wise</b>			14. MOTHER'S MAIDEN NAME <b>Esther (maiden name unknown)</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-4148</b>		17. INFORMANT <b>Ira A. Dashiell, Mardela, Maryland</b>		Address <b>Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>452X</b> DUE TO Cardiac failure			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO  (c) <b>arteriovenous aneurysm external carotid right, unknown</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>acute pyelonephritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.</b>							
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>100 Grove</b>		(County) <b>Delaware</b>	(State) <b>Del.</b>
21. I certify that I attended the deceased from <b>9/1</b> , 19 <b>57</b> , to <b>death</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec 15, 1957</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Ernest Larmore</b> M.D. <b>100 Grove, Del.</b>									
DATE SIGNED <b>12/1/57</b>									
ACTUAL SIGNATURE <b>Ernest Larmore</b>		PHYSICIAN'S NAME (Type) <b>ERNEST LARMORE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>John Wesley Cemetery</b>		22d. LOCATION (City, town, or county) <b>Mardela, Maryland</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S.  
DEC 23 1957  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13736

332

13765

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fruitland</b>		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>Isabella Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Isabella Street</b>									
3. NAME OF DECEASED (Type or print) <b>Hannah</b>		First	Middle	Last	4. DATE OF DEATH <b>Deal</b>	Month <b>12</b>	Day <b>10</b>	Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>93</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Virgil Deal</b>		Address <b>Fruitland Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		<b>Cerebroscerosis</b> <b>Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>Indefinite</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>652 W main St.</b>		(County) <b>Salisbury</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>10 Sept. 1957</b> to <b>10 Dec. 1957</b> , that I last saw the deceased alive on <b>10 Dec. 1957</b> , and that death occurred at <b>720</b> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>652 W main St., Salisbury, Maryland</b>					DATE SIGNED
ACTUAL SIGNATURE <b>E.A. Purnell</b>									
PHYSICIAN'S NAME (Type) <b>E.A. Purnell</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12 13 57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Calvary</b>		22d. LOCATION (City, town, or county) <b>Fruitland</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinten F. Stewart</b>		ADDRESS <b>Salisbury Md.</b>		24e. REC'D BY REGISTRAR <b>DEC 1 1957</b>		24f. REGISTRAR'S SIGNATURE <b>Mary J. Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE GOVERNMENT OF HENRY - BAILIFFAGE 12  
CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE

BUREAU V. S.

DEC 16 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13723 CERTIFICATE OF DEATH

13737  
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>12</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		
3. NAME OF DECEASED (Type or print) <b>GOLLEY</b>		4. DATE OF DEATH <b>DILL</b> DECEMBER 26th 19 57		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 17, 1902</b>	
		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>55 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
13. FATHER'S NAME <b>Alexander Dill</b>		14. MOTHER'S MAIDEN NAME <b>Priscilla</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Norma G. Scott (Daughter) #44 Cherry Way Salisbury, Maryland</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.1</b> DUE TO Congenital failure		INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/7</b> , 19 <b>57</b> , to <b>12/26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/26</b> , 19 <b>57</b> , and that death occurred at <b>7:30P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Dr. Andrew C. Mitchell</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 29, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Odd Fellow Cemetery</b>	22d. LOCATION (City, town, or county) <b>Camden, Delaware</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>TORBERT FUNERAL SERVICE - DOVER, DELAWARE</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>DEC. 30 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 ESTATE PLANNING TO TRANSFER STATE OWNED

BUREAU A. 8

250 30 05

**REFUGEE**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13724

## CERTIFICATE OF DEATH

Reg. Disk No. 13738337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>306 Martin St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>IDA</b>	Middle <b>ISABELLE</b>	Last <b>DILL</b>
4. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Bishopville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Hudson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ida Mae Swinehart (Daughter) 306 Martin St. Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/15</b> , 19 <b>57</b> , to <b>12/30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12/30</b> , 19 <b>57</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Earl Beardsley</b>		ADDRESS (Street, city or town, state) <b>Maryland Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 2, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME • SALISBURY, MD.</b>		ADDRESS <b>JAN 3 1958</b>	
		24a. REC'D BY REGISTRAR <b>Mary Holloway</b>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13725

## CERTIFICATE OF DEATH

13731  
932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
WICOMICO MARYLAND		MARYLAND SOMERSET ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
SALISBURY	6 WEEKS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
SPRINGHILL SANATORIUM	RURAL POCOMOKE CITY 19x2-2		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	SALLIE	C.	DRYDEN
4. DATE OF DEATH	Month	Day	Year
	DEC.	26	1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	FEB. 14-1872
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
85	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
HOUSEWIFE		—	MARYLAND
12. CITIZEN OF WHAT COUNTRY?			
USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOSEPH W. TILGHMAN		CATHERINE CLUFF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		Address	
—		CLIFFORD M. DRYDEN, POCOMOKE	
16. SOCIAL SECURITY NO.		17. INFORMANT	
IXONE		C. CLIFFORD M. DRYDEN, POCOMOKE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		2 months	
332X		Cerebral Thrombosis	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b)		Cerebral Atherosclerosis	
DUE TO		—	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 1957 to Dec. 26, 1957, that I last saw the deceased alive on Dec. 26, 1957, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		12/28/57	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
PRESBYTERIAN		REHOBOTH MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REG'D BY REGISTRAR	
Henry Stevenson Pocomoke Md.		DATE DEC 30 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Mary Holloway			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - OFFICE OF INFORMATION

CERTIFICATE OF DATA

BUREAU V.

DEC 30 1957

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The both copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****13766 CERTIFICATE OF DEATH**

13740

335

Reg. Dist. No.

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Wicomico Sharpstown	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET ADDRESS
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Railway Street	20 yrs x0	Wicomico Sharpstown (If rural give location)
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
(First) Pearl		(Month) (Day) (Year) Dec. 23 1957	
(Middle)	Eaton		
(Last)		9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Deyrs Hours Min.
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 9, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Benjamin Eaton, Sharptown, Md.
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO <u>Hypertension + Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, (B) <u>Chilis Vasculitis Disease</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/25/57</u> , 1957, to <u>12/23/57</u> , 1957, that I last saw the deceased alive on <u>12/23/57</u> , 1957, and that death occurred at <u>6 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Charles M. Mayes</u> M.D. ADDRESS (Street, city, town, state) <u>Laurel Hill</u> DATE SIGNED <u>12/23/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-26-57	NAME OF CEMETERY OR CREMATORIAL Firemans
24. REC'D BY REGISTRAR DATE DEC 30 1957		REGISTRAR'S SIGNATURE <u>Mary C. O'Conor</u>	LOCATION (City, town, or county) (State) Sharptown, Md.
		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Mayes, Sharptown, Md.</u>	ADDRESS

BY EQUALITY OF STATEMENT OR TESTIMONY OF THE STATE OR A PARTY

STATE TO STATE CERTIFICATE

1957 DECEMBER

STATEMENT OF JOHN RICHARDSON

STATEMENT OF JOHN RICHARDSON

STATEMENT OF JOHN RICHARDSON

STATEMENT OF JOHN RICHARDSON

STATEMENT

STATEMENT

STATEMENT OF JOHN RICHARDSON

BUREAU V. 81

DEC 30 1957

RECEIVED

John W. Nichols  
John W. Nichols

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13741

13726

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>6 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		d. STREET ADDRESS <u>Princess Anne, Md.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Valentine</u>		First	Middle	Last	4. DATE OF DEATH <u>Ebby</u>	Month	Day	Year
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Feb 14 1886</u>	9. AGE (In years last birthday) <u>91 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Samuel Ebby</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Choper</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>211-30-8043</u>		17. INFORMANT <u>Ward</u>		Address <u>100 Rabbit Street Princess Anne</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>155X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		GENERALIZED ABDOMINAL CARCINOMA				INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Princess Anne</u>		(County) <u>Md.</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>12-25-</u> , 19 <u>57</u> , to <u>12-31-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-31-57</u> , 19 <u>57</u> , and that death occurred at <u>11:10 AM</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>12-31-57</u>
ACTUAL SIGNATURE <u>W. E. Valentine Jr.</u>								
PHYSICIAN'S NAME (Type) <u>James Lemon</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial Jan 3 1958</u>		22b. DATE THEREOF <u>Jan 3 1958</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Crescent Cemetery</u>		22d. LOCATION (City, town, County) <u>Princess Anne, Md.</u>		(State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Lemon</u>		ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>1958</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Hallaway</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

John Doe

1911

BUREAU V. S.

JAN 6 1968

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13767

## CERTIFICATE OF DEATH

Reg. Dist. No.

13742  
337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 3 (Zion Rd)</b>				d. STREET ADDRESS <b>R.D.# 3 (Zion Rd)</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>EDITH</b>		First	Middle <b>MATILDA</b>	Last <b>FARLOW</b>	4. DATE OF DEATH <b>DECEMBER 21st 1957</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1885</b>	9. AGE (In years less birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR <b>5 Months</b>	IF UNDER 24 HRS. <b>16 Hours</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico County Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>John Handy Livingston</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Matilda Ruzek</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. George W. Farlow (Husband) R.D.# 3 Zion Rd. Salisbury, Maryland</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of Liver</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Congestive Heart Failure</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fruitland, Maryland</b>		20f. (City or town) <b>Fruitland</b>	(County) <b>Fruitland</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ADDRESS (Street, city or town, state) <b>Fruitland, Maryland</b>								
ACTUAL SIGNATURE <i>Lee Lawry</i>		M.D.		DATE SIGNED <b>Dec. 12/11/1957</b>				
PHYSICIAN'S NAME (Type) <b>Dr. Lee Lawry</b>		Fruitland, Maryland		Dec. 12/11/1957				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>120 E. Main Street, Salisbury, Maryland</b>		24. REGISTRAR'S SIGNATURE <b>DEC 27 1957</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the register, or prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13743

## 13727 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>2yrs 3mo. 16days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland</b>		d. STREET ADDRESS <b>Academy Street</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Ethel</b>	Middle <b>Ball</b>	Last <b>Fountain</b>	4. DATE OF DEATH Month <b>Dec.</b>	Day <b>15</b>	Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 2, 1877</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Anderton Fountain</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Mills</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Acute heart failure INTERVAL BETWEEN ONSET AND DEATH yrs. <b>1 day</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Aug. 8, 1955</b> , to <b>Dec. 15, 1957</b> , that I last saw the deceased alive on <b>Dec. 15, 1957</b> , and that death occurred at <b>9:09 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Gerhard Kosmahl</b> M.D. <b>Salisbury, Maryland</b> <b>12/15/57</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Dorchester Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John DeGraff Jr.</b>		ADDRESS <b>Cambridge, Md</b>		24a. REC'D BY REGISTRAR DATE <b>12/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>John DeGraff Jr.</b> <b>Mary Holloway</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE: CALIFORNIA DEPARTMENT OF MOTOR VEHICLES

DEC 23 1957

**REGELIV ED**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13744

## 13728 CERTIFICATE OF DEATH

Reg. Dist. No.

33r

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WORCESTER</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>ELIJAH THOMAS GARLICK</b>		First	Middle	Lost	4. DATE OF DEATH <b>DECEMBER 2 1957</b>	Month	Day	Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 19, 1880</b>	9. AGE (In years lost birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PUBLISHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAILY PAPER</b>		11. BIRTHPLACE (State or foreign country) <b>OLDHAM, ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JAMES WILLIAM GARLICK</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>MR. S. WILLIAM GARLICK, OCEAN CITY MD</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<b>Mesenteric Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m.      p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>12/11/57</b> to <b>12/2/57</b> , that I last saw the deceased alive on <b>12/12/57</b> , and that death occurred at <b>11:55 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>H. P. Brielle</b>		M.D.		ADDRESS (Street, city or town, state) <b>Medical Center 17-3-37 Salisbury, Md</b>		DATE SIGNED <b>12/3/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/6/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) <b>BERLIN</b> (State) <b>M.D.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burley Berlin and</b>		ADDRESS <b>1205</b>		24a. REC'D BY REGISTRAR <b>Dec 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE - WASHINGTON 25  
U.S.A. CERTIFICATE OF DEATH

BUREAU U.S.  
RECEIVED  
MAY 5 1957

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8 &amp; 9, Film G225. 2/14/58 fcy

13746  
332

## CERTIFICATE OF DEATH

Reg. Dist. No.....

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## INSTRUCTIONS

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Ellicott City</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Salisbury</i>	LENGTH OF STAY (in this place) <i>20</i>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Salisbury Md</i>	STREET ADDRESS <i>100</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Salisbury</i>			(If rural give location)
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Jennie M. Gandy</i>		<b>4. DATE</b> (Month) <b>(Dey)</b> <b>(Year)</b> <b>OF DEATH</b> <i>12 29 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-27-1902</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTHPLACE (State or foreign country) <i>S.C.</i>
13. FATHER'S NAME <i>Sam Hogwood</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-4-3382</i>	
17. INFORMANT & ADDRESS <i>Hogwood Gandy</i>		18. MEDICAL CERTIFICATION <i>Wremia subacute glomerulonephritis</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE <i>591X</i> (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH <i>10 day 10 month</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Hypertension, hyperuric acid disease</i>		?	
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 26, 1957</i> , to <i>Dec 29, 1957</i> , that I last saw the deceased alive on <i>Dec 29, 1957</i> , and that death occurred at <i>10:20 AM</i> , from the causes and on the date stated above. SIGNATURE <i>A. V. Sotler</i> M. D. ADDRESS (Street, city, town, state) <i>Elmwood Rd.</i> DATE SIGNED <i>12-30-57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-2-57</i>	NAME OF CEMETERY OR CREMATORIAL <i>Blue Hill Cemetery Parsonsburg MD</i>
24. REC'D BY REGISTRAR DATE <i>Mary Hollaway</i>		LOCATION (City, town, or county) (State)	
REGISTRAR'S SIGNATURE <i>Mary Hollaway</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Booker Black</i>	

JAN 6 1958

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BUREAU OF

REGISTRATION OF DEATHS

REGISTRATION

REGISTRATION OF DEATHS

BUREAU V. 2

JAN 6 1953

REGISTRATION OF DEATHS

FOR STATE

HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13745  
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b>		c. LENGTH OF STAY IN 1b <b>life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO R F D # 1 Quantico</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>R F D # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Georgia</b>		First <b>Emily</b>	Middle <b>Gates</b>	Last <b></b>	4. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>1957</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>68 (11-12-1889)</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>George Price</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Jones</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-3636</b>		17. INFORMANT <b>Mrs. Emma Dorman, Quantico, Md.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>420.1</b>		DUE TO <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <b>Arterio-sclerotic cardio-vascular disease Years</b>							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) <b></b> (State) <b></b>					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12-20-57</b>					
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-22-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Head Creek Cemetery</b>		22d. LOCATION (City, town, or county) <b>Quantico, R F D # 1, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home Salisbury, Md.</b>				24a. REC'D BY REGISTRAR <b>D E</b>		24b. REGISTRAR'S SIGNATURE <b>27 1957</b>			

BUREAU V. S.  
RECEIVED

DEC 27 1957

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The both copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 13730 CERTIFICATE OF DEATH

13747  
337

Reg. Dist. No.....

## 1. PLACE OF DEATH

COUNTY	Wicomico	MARYLAND
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)
TOWN	Salisbury	2½ yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Pine Bluff State Hospital	

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	Maryland	COUNTY	Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town)	XO	TOWN	Rural-Salisbury
STREET ADDRESS	(If rural give location)		
R.F.D. # 2			

## 3. NAME OF DECEASED (First) (Middle) (Last)

Emma Elizabeth Haddock

## 4. SEX

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

W

## 8. DATE OF BIRTH

Feb. 28, 1884

## 9. AGE last birthday

73

yrs. (Month) (Day) (Year)

19 57

IF UNDER 1 YEAR  
Months Dey Hours Min.

## 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Delaware

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Benjamin Ellingsworth

## 14. MOTHER'S MAIDEN NAME

Martha Tumie

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY NO.

none

## 17. INFORMANT &amp; ADDRESS

Mr. William A. Haddock (Son)  
Records of Pine Bluff State Hosp. R.D. #2

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X IMMEDIATE CAUSE

(A)

Pulmonary tuberculosis

INTERVAL BETWEEN  
ONSET AND DEATH  
3 yrs.ANTECEDENT CAUSE(S) DUE TO  
DISEASES OR CONDITIONS, IF ANY, (B)  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO  
(C)

## 18. MEDICAL CERTIFICATION

Salisbury, MD

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19e. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21e. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While   
at work  Not while   
at work 

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from..... Jul. 1, 1957, to Dec. 8, 1957, that I last saw the deceased alive on Dec. 7, 1957, and that death occurred at 7:30 P.M. from the causes and on the date stated above. 12/8/57  
ADDRESS (Street, city, town, state) 12/8/57 SIGNED

SIGNATURE

E.P. Ritchings, M.D.

M.D. Pine Bluff State Hospital, Salisbury, Md.

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
Burial

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county)

(State)

Dec. 11, 1957

Line Church Cemetery

R.D. # Pittsville, Maryland

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

DEC 11 1957 Mary Holloway, HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU

CERTIFICATE OF DEATH

State of New York

County of New York

City of New York

Date of Birth: 1900

Date of Death: 1957

Age at Death: 57

Place of Birth: New York City

Place of Death: New York City

Place of Burial: New York City

Occupation: Retired

Occupation: Retired

Occupation: Retired

Religion: Protestant

Religion: Protestant

Religion: Protestant

Marital Status: Married

Marital Status: Married

Marital Status: Married

Employment: Retired

Employment: Retired

Employment: Retired

Address: 123 Main Street

Address: 123 Main Street

Address: 123 Main Street

City: New York

City: New York

City: New York

State: New York

State: New York

State: New York

Zip Code: 100-00

Zip Code: 100-00

Zip Code: 100-00

Phone Number: 123-4567

Phone Number: 123-4567

Phone Number: 123-4567

Date of Birth: 1900

Date of Birth: 1900

Date of Birth: 1900

Date of Death: 1957

Date of Death: 1957

Date of Death: 1957

Place of Birth: New York City

Place of Birth: New York City

Place of Birth: New York City

Occupation: Retired

Occupation: Retired

Occupation: Retired

Religion: Protestant

Religion: Protestant

Religion: Protestant

Marital Status: Married

Marital Status: Married

Marital Status: Married

Employment: Retired

Employment: Retired

Employment: Retired

Address: 123 Main Street

Address: 123 Main Street

Address: 123 Main Street

City: New York

City: New York

City: New York

State: New York

State: New York

State: New York

Zip Code: 100-00

Zip Code: 100-00

Zip Code: 100-00

Phone Number: 123-4567

Phone Number: 123-4567

Phone Number: 123-4567

Date of Birth: 1900

Date of Birth: 1900

Date of Birth: 1900

Date of Death: 1957

Date of Death: 1957

Date of Death: 1957

Place of Birth: New York City

Place of Birth: New York City

Place of Birth: New York City

Occupation: Retired

Occupation: Retired

Occupation: Retired

Religion: Protestant

Religion: Protestant

Religion: Protestant

Marital Status: Married

Marital Status: Married

Marital Status: Married

Employment: Retired

Employment: Retired

Employment: Retired

Address: 123 Main Street

Address: 123 Main Street

Address: 123 Main Street

City: New York

City: New York

City: New York

State: New York

State: New York

State: New York

Zip Code: 100-00

Zip Code: 100-00

Zip Code: 100-00

BUREAU V. S.

DEC 11 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**13731 CERTIFICATE OF DEATH**

13748  
332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				
3. NAME OF DECEASED (Type or print) <b>Helen</b>		d. STREET ADDRESS <b>55 Calvert Street</b>				
4. DATE OF DEATH <b>Dec. 3</b>		Month <b>Dec.</b>	Day <b>3</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>1/17/1914</b>		9. AGE (In years (as of birthday) <b>43</b> yrs.)	10. IF UNDER 1 YEAR Months <b>0</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. IF UNDER 24 HRS. Days <b>0</b>	13. IF HOURS Hours <b>0</b>			
14. CITIZEN OF WHAT COUNTRY? <b>USA</b>		15. FATHER'S NAME <b>Frank Abrams</b>				
16. MOTHER'S MAIDEN NAME <b>Anna Francis</b>		17. SOCIAL SECURITY NO.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Hepatic Coma</b> DUE TO (c) <b>Laennec's cirrhosis of liver</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Deer's Head State Hospital</b>	20f. (City or town) <b>Salisbury</b>	(County) <b>Maryland</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Sept. 3, 1957</b> , to <b>Dec. 3, 1957</b> , that I last saw the deceased alive on <b>Dec. 3, 1957</b> , and that death occurred at <b>5:15 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>V. Juerman</b>		M.D.		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-8-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Brevort Hill</b>	22d. LOCATION (City, town, or county) <b>Annapolis Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Beesett, 108 West St. Annapolis Md.</b>		ADDRESS <b>108 West St. Annapolis Md.</b>	24a. REC'D BY REGISTRAR DATE <b>12/9/57</b>	24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 10 1957

REGGAE V EDU

13749

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it, certifying, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 338

I. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>8 Maryland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b>	First	Middle <b>Elizabeth</b>	Hitchens	4. DATE OF DEATH <b>12-</b>	Month <b>20</b>	Doy <b>19</b>	Year <b>57</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 2, 1892</b>	9. AGE (In years last birthday) <b>65 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Hitchens</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-30-8695</b>		17. INFORMANT <b>Arthur Hitchens, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>916.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2nd and 3rd degree burns of 80% of body surface.</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothing caught fire when stove exploded.</b>							
20c. TIME OF INJURY Hour o. m. <b>12-11-</b> 1957		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input checked="" type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing home.</b>		(County) <b>Delmar</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Nutrool causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>12-23-57</b>		
22a. BURIAL, CREMATION, REMOVAL(S) (City) <b>Burial</b>	22b. DATE THEREOF <b>12-22-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>First Methodist</b>	22d. LOCATION (City, town, or county) <b>Delmar, Del.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. S. Mason Co. Delmar, Del.</i>	ADDRESS <b>8 Maryland Ave., Delmar, Del.</b>	24a. REC'D BY REGISTRAR <b>REC'D 27 1957</b>	24b. REGISTRAR'S SIGNATURE <i>Mary Hollingshead</i>				
VS. A15ME 5M 2/57							

NEW YORK STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SEARCHED  
INDEXED

BUREAU Y.

DEC 27 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13769

## CERTIFICATE OF DEATH

13750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar Md.</b>		c. LENGTH OF STAY IN 1b		a. STATE <b>Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Holloway Nursing Home</b>		e. STREET ADDRESS		b. COUNTY <b>Wicomico</b>	
3. NAME OF DECEASED (Type or print) <b>Levin</b>		First <b>Franklin</b>	Middle <b>Holbrook</b>	Last <b></b>	4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>not known about 88 yrs.</i>	9. AGE (In years lost birthday) yrs. <b>88</b>	10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. 11. IF UNDER 24 MRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Former Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Stanley Holbrook</b>		14. MOTHER'S MAIDEN NAME <b>Ella Smith</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Gladys Brown Sharptown Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO <b>Unknown</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>					
DUE TO (c) <b>Hypertension</b> DUE TO <b>Unknown</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Dec 5, 1957</b>	
20f. (City or town) <b>Salisbury</b> (County) <b>Md.</b> (State)					
21. I certify that I attended the deceased from <b>Nov 22, 1957</b> to <b>Dec 5, 1957</b> , that I last saw the deceased alive on <b>Dec 2, 1957</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>Salisbury Md</b> DATE SIGNED <b>12/16/57</b>					
ACTUAL SIGNATURE <b>G. Herbert Bemby M.D.</b>					
PHYSICIAN'S NAME (Type) <b>G. Herbert Bemby</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Green Acres</b>	
22d. LOCATION (City, town, or county) <b>Salisbury</b> (State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton Stewart. Salisbury Md.</b> ADDRESS					
24a. REC'D BY REGISTRAR <b>DEC 9 57</b>		24b. REGISTRAR'S SIGNATURE <b>D. Smith</b>			

STATE OF CALIFORNIA - BUREAU OF MOTOR VEHICLES

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
DEC 9 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13733 CERTIFICATE OF DEATH

1375B32  
26

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2½ mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station		19x12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First William	Middle --	Last Horsey	4. DATE OF DEATH December 6th, 1957	Month Day Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG 28-1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Marion Station, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Lord		14. MOTHER'S MAIDEN NAME Eliza Gale					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. 215-16-8180		17. INFORMANT Deer's Head State Hospital, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1		Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		Arteriosclerosis, generalized		?			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 23 1957, to December 6 1957, that I last saw the deceased alive on December 6, 1957, and that death occurred at 7:40 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE  L. V. Maldve, M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED 12/7/57			
PHYSICIAN'S NAME (Type)		M.D.		Deer's Head State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, '57		22c. NAME OF CEMETERY OR Crematory Family Cemetery		22d. LOCATION (City, town, or county) Marion Sta., Som. Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward		ADDRESS Marion Sta., Md.		24a. REC'D BY REGISTRAR DATE 12-11-57		24b. REGISTRAR'S SIGNATURE Nellie D. Peay - Mary McAllister	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU # 1

DEC 13 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13734 CERTIFICATE OF DEATH

13752

337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Gloucester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bedlin</i>		d. STREET ADDRESS <i>R.F.D.#2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle	Last <i>Hudson</i>	4. DATE OF DEATH	Month <i>December</i>	Day <i>16</i>	Year <i>1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-16-1867</i>	9. AGE (In years last birthday) yrs. <i>90</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John A. Hudson</i>		14. MOTHER'S MAIDEN NAME <i>Annie Puttitt</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <i>None</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>The Rudolph Hudson, Berlin, Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>Chronic Myocarditis</i> DUE TO (c) <i>Hyperension</i>				INTERVAL BETWEEN ONSET AND DEATH <i>few days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>10</i>		20f. (City or town) <i>Dec. 15, 1957</i>		(County) <i>Dec. 16, 1957</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>Dec. 15, 1957</i> to <i>Dec. 16, 1957</i> that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>12:28 A.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i>		DATE SIGNED <i>12/19/57</i>	
ACTUAL SIGNATURE <i>G. Herbert Scembly</i>		PHYSICIAN'S NAME (Type) <i>G. Herbert Scembly M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-19-1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>EVERGREEN CEMETERY</i>		22d. LOCATION (City, town, or county) <i>BERLIN, MD</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Stewart FUNERAL HOME, SALISBURY</i>		ADDRESS <i>100 E. Main Street, Salisbury, MD</i>		24a. REC'D. BY REGISTRAR DATE <i>DEC 27 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary Holloway</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, which will be detached for use as the burial-transit permit. Then please remove removal, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE GOVERNMENT OF HAWAII - CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.  
DEC 37 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13735 CERTIFICATE OF DEATH

13753  
337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>WICOMICO</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>WICOMICO</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parsonsburg, xo</i>		d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA General Hosp.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Goldie</i>	Middle <i></i>	Last <i>ISAAC</i>	4. DATE OF DEATH <i>December 13, 1957</i>	Month <i>December</i>	Day <i>13</i>	Year <i>1957</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 18, 1884</i>	9. AGE (In years last birthday) <i>73</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	13. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Owen Isaac</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Jane Marvel</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Clara Dodds, 5041 N. Fairhill St., Philadelphia, Pa.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Antemortem heart disease				INTERVAL BETWEEN ONSET AND DEATH <i>2 hr 10 min</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Milford, Del.</i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>11-6-1957</i> to <i>12-13-1957</i> , that I last saw the deceased alive on <i>Dec. 13, 1957</i> , and that death occurred at <i>11:59 M</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Peninsula Gen. Hosp., Salisbury, Md.</i>		DATE SIGNED <i>12/13/57</i>			
ACTUAL SIGNATURE <i>Anthony Bernardo</i>		M.D.							
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/17/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Odd Fellows</i>		22d. LOCATION (City, town, or county) <i>Milford, Del.</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Berry Jr.</i>		ADDRESS <i>Milford, Del.</i>		24a. RECD. BY REGISTRAR <i>DEC 16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary Holloway</i>			

## CERTIFICATE OF DEATH

BUREAU V. S.

DEC 16 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13770

## CERTIFICATE OF DEATH

13754

337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>In Village</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	
d. STREET ADDRESS 1		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. NAME OF DECEASED (Type or print) <b>GEORGE</b>		First <b>GEORGE</b> Middle <b>TILTON</b> Last <b>JACKSON</b>	
f. SEX <b>Male</b>		g. COLOR OR RACE White	
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		i. DATE OF BIRTH <b>October 17, 1876</b>	
j. WIDOWED <input type="checkbox"/>		k. DIVORCED <input type="checkbox"/>	
l. AGE (In years last birthday) <b>81</b>		m. IF UNDER 1 YEAR Months <b>2</b> Days <b>13</b> Hours <b>0</b> Min. <b>0</b>	
n. IF UNDER 24 HRS. yrs. <b>0</b>		o. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Tilghmans Island, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Mrs. Elsie J. Jackson (Wife)</b> Address <b>Pittsville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), DUE TO Conditions, if any, which gove rise to immediate cause (a), stating the under- lying cause lost. <b>434.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
(b), DUE TO DUE TO (c)		degenerative heart failure. degenerative heart disease. <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/15/57</b> to <b>12/29/57</b> , that I last saw the deceased alive on <b>12/29/57</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Maryland Ave. Salisbury, Maryland</b> DATE SIGNED <b>Earl Beardsley</b> <b>Dec. 130/57</b>	
ACTUAL SIGNATURE <b>Earl Beardsley</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. Earl Beardsley</b>		Maryland Ave. Salisbury, Maryland Dec. 130/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 2, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Pittsville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>130/57</b>	
		24a. REC'D BY REGISTRAR <b>130/57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

BUREAU V. S.

803 3 N

**REGELVÉD**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No.	
13771 CERTIFICATE OF DEATH										13755	
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tyaskin</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tyaskin</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 					d. STREET ADDRESS <b>/</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MAMIE</b>		First <b>INSLEY</b>		Middle <b>JARRETT</b>		4. DATE OF DEATH <b>Dec. 22 1957</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/20/95</b>		9. AGE (In years lost birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>2</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		
13. FATHER'S NAME <b>Slemons S. Jarrett</b>					14. MOTHER'S MAIDEN NAME <b>Virginia Messick</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>-----</b>			17. INFORMANT <b>Arlie Jarrett, Tyaskin, Maryland</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>Cerebral Hemorrhage</b> <b>Cerebral Convulsions</b> <b>3 Digital</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nanticoke, Maryland</b>			20f. (City or town) (County) <b>Nanticoke</b> (State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>12/28/56</b> to <b>12/22/57</b> , that I last saw the deceased alive on <b>12/22/57</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Richard H. Saunders M.D.</b> PHYSICIAN'S NAME (Type) <b>Richard H. Saunders</b> ADDRESS <b>Nanticoke, Maryland</b> DATE SIGNED <b>12/24/57</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Tyaskin Cem.</b>			22d. LOCATION (City, town, or county) <b>Tyaskin, Maryland</b>			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard H. Messick</b> , Bivalve, Maryland					ADDRESS <b>Bivalve, Maryland</b>			24a. REC'D BY REGISTRAR <b>JAN 8 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Richard H. Messick</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG224 1-3-58 et

13736

## CERTIFICATE OF DEATH

13756 337  
Reg. Dist. No. 261

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Wicomico				o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Somerset	
Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		d. STREET ADDRESS	
Peninsula General Hospital		RT. #1 - BOX 366		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Nathaniel				Johnson	Month Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 51 yrs.
Male		Colored		04-06-1906	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				MARION SOMERSET U.S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Levin Johnson		Sarah Marshall		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(If yes, give war or dates of service)		217-05-807		FAY ELYN JOHNSON MARION NY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Posterior Myocardial Infarction 2 weeks			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Arteriosclerotic Cardiovascular Dis. (c) Congestive Heart Failure			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
p. m.				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/17, 1957, to 12/19, 1957, that I last saw the deceased alive on 12/18, 1957, and that death occurred at 6:00 AM, from the causes and on the date stated above.		ADDRESS (Street, city, or town, state)			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		DATE SIGNED Rufus S. Gardner, Jr. M.D. 321 S Div. St. 12/20/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Burial		12/22/57		John Wesley Marion Sta., Som. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Charles H. Ward		Marion St. N.E.		DATE 12-22-57	
24b. REGISTRAR'S SIGNATURE		Mary H. Holloway			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE  
CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.  
1957  
15C - 2

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13772

## CERTIFICATE OF DEATH

13757

Reg. Dist. No. 337

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b>		b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Head of Creek</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quantico</b>		d. STREET ADDRESS <b>XO</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>OR INSTITUTION</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ida B. Jones</b>		First	Middle	Last	4. DATE OF DEATH <b>12 10 1957</b>	Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b>	B. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years lost birthday) yrs. <b>82</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Robinson</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mathew Jones</b>		Address <b>Quantico Md. R. F. 1</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <b>Arterio sclerotic Heart Disease</b>				10 Years		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>11/11 1957</b> to <b>12/10 1957</b> , that I last saw the deceased alive on <b>12/10 1957</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Richard H. Saunders M.D.</b>								ADDRESS (Street, city or town, state) <b>Quantico Md.</b>
PHYSICIAN'S NAME (Type) <b>RICHARD H. SAUNDERS.</b>								DATE SIGNED <b>12/12/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/15/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Head of Creek</b>		22d. LOCATION (City, town, or county) <b>Wicomico</b>		(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton C. Stewart Salisbury Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Malloway</b>		

RECEIVED - STATE DEPARTMENT - BUREAU OF INTELLIGENCE

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE

BUREAU V. S.

DEC 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13737

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13758 33Y

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it, certifying, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 1. PLACE OF DEATH

o. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

3 Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Peninsula General Hospital

3. NAME OF  
DECEASED  
(Type or print)First  
RubyMiddle  
OpalLast  
Long

## 4. SEX

F

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

DIVORCED 

Jan 5, 1914

9. AGE (In years  
last birthday)

43 yrs.

12-26-57

Month

Day

Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Teaching (School)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Oklahoma

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME

J. A. Crull

## 14. MOTHER'S MAIDEN NAME

Ellen Northrop Crull

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Harry o. Long

Dagsboro, Del.

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which

gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

Fractured skull: intracranial hemorrhage. 2 days

INTERVAL BETWEEN  
ONSET AND DEATH

## MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Injured in an automobile accident. Old Dalmar Rd.

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c. TIME OF INJURY Month Day Year  
11:20 a.m. 12-23-57  
p. m. 1920d. INJURY OCCURRED  
While  
of work  Not while  
of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)  
Street20f. (City or town)  
Salisbury  
(County) Wicomico  
(State) Md.21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Earl L. Royer, M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

DATE SIGNED

12-27-57

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12-29-57

22c. NAME OF CEMETERY OR CREMATORIUM

Red Mens Cemetery

22d. LOCATION (City, town, or county)

(State)

Dagsboro,

Del.

23. FUNERAL DIRECTOR'S SIGNATURE

Watson &amp; Gray Millsboro, Del.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DEC 31 1957 Mary Holloway

WEDNESDAY, DECEMBER 31, 1957

STANISLAW  
HORN

SEARCHED	INDEXED	SERIALIZED	FILED

BUREAU V. S.

DEC 31 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13759

332

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico Co</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN lb <b>8 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Tyaskin</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>EVELYN</b>		First	Middle	Last	4. DATE OF DEATH <b>MASON</b>	Month	Day	Year
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5-3-78</b>	9. AGE (In years lost birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housenew</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aynn Home Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>William</b>		14. MOTHER'S MAIDEN NAME <b>Jones</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Thadys Potts, Jasbin Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 33IX		DUE TO (b)		INTERVAL BETWEEN ONSET AND DEATH <b>2 Wks</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		DUE TO (b)		Generalized Arteriosclerosis 10 Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5/27/57</b> to <b>12/2/57</b> , that I last saw the deceased alive on <b>12/2/57</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>NANTICOKE MD 12/4/57</b>		
ACTUAL SIGNATURE <b>D. Richard H. Saunders M.D.</b>								
PHYSICIAN'S NAME (Type) <b>Richard H. SAUNDERS. M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/7/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Tyaskin Cem.</b>		22d. LOCATION (City, town, or county) <b>Tyaskin Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. D. Messick, Bischoff, Md.</b>		ADDRESS <b>15th Street, May Holloway</b>		24a. REC'D BY REGISTRAR <b>DEC 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>May Holloway</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
DEC 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13760

Reg. Dist. No. 337

13739

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

o. COUNTY Wicomico MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY

c. LENGTH OF STAY IN 1b  
RURAL and give nearest town  
82 Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE Maryland b. COUNTY Wicomico ✓

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City

d. STREET ADDRESS 110 W. Wicomico St.

23X2.2

e. IS RESIDENCE ON A FARM? YES  NO 

3. NAME OF DECEASED (Type or print)

First Wilmer

Middle O. MESSICK

4. DATE OF DEATH Month December Doy 6 Year 1957

S. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED 

8. DATE OF BIRTH

DIVORCED 

1-4-87

9. AGE (In years lost birthday)

70 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired police

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

214-12-1672

17. INFORMANT

Family

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

434.3

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

(b)

DUE TO

(c)

Chronic Cor Pulmonale with Congestive Failure

INTERVAL BETWEEN  
ONSET AND DEATHPulmonary Infiltration - Cause  
undetermined

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
While Not while  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County)

(State)

21. I certify that I attended the deceased from Dec 1, 1957, to Dec 7, 1957, that I last saw the deceased alive on Dec 7, 1957, and that death occurred at 2 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Thomas C. Tilly Jr. M.D.

PHYSICIAN'S  
NAME (Type)22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12-10-57

22c. NAME OF CEMETERY OR CREMATORIUM

Western Cem.

22d. LOCATION (City, town, or county)

Baltimore Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

McColly Funeral Home

ADDRESS

130 E. Fort Ave.

24a. REC'D BY REGISTRAR

DATE DEC 10 1957

24b. REGISTRAR'S SIGNATURE

Mary Holloway

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13761

13740

## CERTIFICATE OF DEATH

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 14 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deal Island 19X2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital			d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Dossie	Middle Vealie	Last Milbourne	4. DATE OF DEATH Month Dec. 8, Day 19 Year 57
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1878		9. AGE (In years lost birthday) 79 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --			10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Deal Island, Md.
13. FATHER'S NAME Levin Milbourne			14. MOTHER'S MAIDEN NAME Margaret Long		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO.		17. INFORMANT Deer's Head State Hospital, Salisbury, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of right face DUE TO 191X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.	Month, Day, Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from October 3, 1957, to Dec. 8, 1957, that I last saw the deceased alive on Dec. 8, 1957, and that death occurred at 9:55 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. Deer's Head State Hospital 12/9/57 L. V. Maldve, M. D.					
PHYSICIAN'S NAME (Type)		Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 11/11/57	22c. NAME OF CEMETERY OR Crematory John Westfall	22d. LOCATION (City, town, or county) Deal Island	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Burke		ADDRESS Burke Deal Island	RECD BY REGISTRAR DATE 12/12/57	24b. REGISTRAR'S SIGNATURE Lala J. Whitley Mary H. Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 2 1963

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute his certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13762

13741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 337

Item 9 F11mG223 12-19-57 et

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 205 Walnut St		d. STREET ADDRESS 205 Walnut Street	
3. NAME OF DECEASED (Type or print) First AGNES Middle M MITTEN	4. DATE OF DEATH Month DECEMBER Doy 1 st Year 1957		
5. SEX Female White	6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 26, Approx. 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (State or foreign country) Baltimore Maryland
13. FATHER'S NAME Elmer E. Estes		14. MOTHER'S MAIDEN NAME Thressa Sutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Wendell Vickers (Friend) Address 825 Roslyn Ave. Cambridge, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease- Years. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED December 2 1957
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 4, 1957	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) Chestertown, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE LeCOMpte FUNERAL SERVICE - CAMBRIDGE, MARYLAND	ADDRESS	24a. REC'D BY REGISTRAR DATE 12/4/57	24b. REGISTRAR'S SIGNATURE <i>John Moore Jr. Mary J. Hollingsworth</i>

RECEIVED  
BUREAU V. S.

DEC 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 13, 14 File #223 12-30-77 et

13742

## CERTIFICATE OF DEATH

13763

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>	c. LENGTH OF STAY IN 1b <u>4 Mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u> 1939-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>JAMES</u>	First <u>L.</u>	Middle <u>NELSON</u>	4. DATE OF DEATH <u>12 19 1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Merchandise</u>	11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>
13. FATHER'S NAME <u>Lorenzo Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Lawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		DUE TO _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 22</u> , 1957, to <u>12-19</u> , 1957, that I last saw the deceased alive on <u>12-19</u> , 1957, and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip Tinsky</u>		ADDRESS (Street, city or town, state) <u>Jalobury Md. 12-20-57</u>	
PHYSICIAN'S NAME (Type) <u>Philip A. Tinsky</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 22, 1957</u>	22c. NAME OF CEMETERY OR CREMATORIES <u>CRISFIELD CEMETERY</u>
22d. LOCATION (City, town, or county) (State)		CRISFIELD, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Bushaw</u>		ADDRESS <u>BUSHAW &amp; SONS - CRISFIELD MD.</u>	
D 24. REG'D BY REGISTRAR DATE <u>DEC 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED - 6514560 - CALIFORNIA STATE DEPARTMENT OF DEFENSE - 18

DEATH CERTIFICATE

100-100

BUREAU V. S.  
RECEIVED  
DEC 6 1967

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13743

## CERTIFICATE OF DEATH

13764 337  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WICOMICO</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WICOMICO</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		d. STREET ADDRESS <b>404 1/2 CAMDEN AVE.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PENINSULA GENERAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>MARY</b>	Middle <b>Washington</b>	Last <b>NELSON</b>	4. DATE OF DEATH <b>DECEMBER 2 1957</b>	Month	Day	Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>MAR 13 1891</b>	9. AGE (In years lost birthday) yrs. <b>66</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS. Days <b>19</b>	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>Thomas Henry Purcell</b>				14. MOTHER'S MAIDEN NAME <b>Ella Rhee Bradley</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Herman E. Coulter (Daughter) 118 Van Buren St. Salisbury, Maryland</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Bradlands Pneumonia - Diabetes Mellitus</b>								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>260X</b>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>16 yrs.</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m.      p.m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>211 Maryland Ave</b>	(County) <b>Salisbury, Md.</b>	(State) <b>12-3-57</b>
21. I certify that I attended the deceased from <b>11/25 1957</b> to <b>12/2 1957</b> , that I last saw the deceased alive on <b>12/1 1957</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Andrew C. Mitchell M.D.</b>								
ADDRESS (Street, city or town, state) <b>211 Maryland Ave Salisbury, Md.</b>								
DATE SIGNED <b>12/2/57</b>								
PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		22b. DATE THEREOF <b>Dec. 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>		
22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22f. DATE THEREOF <b>Dec. 4, 1957</b>		22g. NAME OF CEMETERY OR CREMATORIAL <b>Wicomico Memorial Park</b>		22h. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME SALISBURY, MD.</b>		ADDRESS <b>HOLLOWAY &amp; COMPANY FUNERAL HOME SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 5</b>		24b. REGISTRAR'S SIGNATURE <b>1957 Mary Holloway</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 of the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE GOVERNMENT OF HESKETH - ENTHWISTLE IS

CERTIFICATE OF DEATH

NAME

ADDRESS

AGE

SEX

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DEATH CERTIFICATE

NUMBER

ISSUED BY

DATE

SIGNATURE

STAMP

RECEIVED  
BUREAU V. S.

DEC 5 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13773

## CERTIFICATE OF DEATH

13765

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	c. LENGTH OF STAY IN 1b <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>XXXX</b>	d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>GATTIE</b>	First <b>X</b>	Middle <b>HULDA</b>	Last <b>PALMER</b>
4. DATE OF DEATH <b>Dec. 14, 1957</b>	Month <b>Dec.</b>	Day <b>14</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1886</b>
9. AGE (In years to birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	11. IF UNDER 24 HRS. <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Delaware</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Robert Smith</b>	14. MOTHER'S MAIDEN NAME <b>Rachel Baker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>212-10-9084</b>	17. INFORMANT <b>F. T. Palmer</b>	Address <b>Pittsville Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertension-arteriosclerosis</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 weeks ago-pulmonary infarct (x-ray diagnosis - PG Hospital)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self</b>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Wicomico</b>
(County) <b>Wicomico</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>October 1, 1957</b> , to <b>12-14-1957</b> , that I last saw the deceased alive on <b>12-14-1957</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank R. Lewis</b>	ADDRESS (Street, city or town, state) <b>Willards Maryland</b>		
PHYSICIAN'S NAME (Type) <b>Frank R. Lewis</b>	DATE SIGNED <b>12-17-57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/17/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Pittsville</b>	22d. LOCATION (City, town, or county) <b>Pittsville, Md.</b>
22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Silverville Md.</b>	24a. REC'D BY REGISTRAR <b>Dec 23 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be torn off with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.  
REGELIVEO  
DEC 23 1955

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G223 12-30-57 et

13744

## CERTIFICATE OF DEATH

Reg. Dist. No.

1376532

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>19x2.2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>E</i>	Last <i>Parks</i>	
4. DATE OF DEATH <i>December 5 1957</i>	Month	Day	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 23, 1884</i>	
9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Days <i>8</i>	12. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William John Tyler</i>	14. MOTHER'S MAIDEN NAME <i>Miss Ella Jane</i>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>219-16-4794</i>	17. INFORMANT <i>Mr. Walter Parks</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>33IX</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i></i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of Breast - Metastasis to Brain, fracture left hip</i>	INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <i>Dec 5 1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Oriole Md</i>	20f. (City or town) <i>Oriole Md</i>	(County) <i>Oriole Co</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>Nov. 15, 1957</i> to <i>Dec. 8, 1957</i> , that I last saw the deceased alive on <i>Dec 5, 1957</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>David Holloway M.D.</i> ADDRESS (Street, city or town, state) <i>Oriole Md</i> DATE SIGNED <i>Dec 8, 1957</i>				
PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-11-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oriole Cemetery</i>	22d. LOCATION (City, town, or county) <i>Oriole Md</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewis Wilson Prince</i>	ADDRESS <i>Oriole Md</i>	24a. REC'D. BY REGISTRAR DATE <i>17 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mary J Holloway</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF MOTOR VEHICLES  
CERTIFICATE OF SAFETY

BUREAU N.Y.

DEC 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13745

## CERTIFICATE OF DEATH

137637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>104 Union Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
f. STREET ADDRESS <b>104 Union Ave.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Clara</b>	Middle <b>Esther</b>	Last <b>Parsons</b>
4. DATE OF DEATH	Dec. <b>2.</b>	Month	Day <b>10</b> Year <b>57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1903.</b>
9. AGE (In years last birthday) <b>54</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Delmar Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Greensbury Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Lamenia Elizabeth Hastings.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mr. Furnell W. Parsons (Husband)</b> Address <b>104 Union Ave. Salisbury, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastasis throughout both lungs and left kidney</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
DUE TO <b>170X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Delmar</b> (County) <b>Md.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Dec. 8</b> , 19 <b>57</b> , to <b>Dec. 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Dec. 8</b> , 19 <b>57</b> , and that death occurred at <b>1204</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>303 East Street Delmar</b> DATE SIGNED <b>12-10-57</b>	
ACTUAL SIGNATURE <b>L.V. Sohler</b>		PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b> PHYSICIAN'S ADDRESS <b>303 East Street, Delmar, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 12. 57.</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery.</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Company.</b>		ADDRESS <b>Salisbury, Maryland.</b>	
24a. REC'D BY REGISTRAR DATE <b>C 11 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary H. Holloway</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - CALUMET COUNTY

CERTIFICATE OF DEATH

BUREAU Y.

DEC 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13746

## CERTIFICATE OF DEATH

13768  
Reg. Dist. No. 337

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b>				
c. LENGTH OF STAY IN 1b <b>12</b>		d. STREET ADDRESS <b>133 Truitt</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.O.A. Pen. Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ADDIE</b>	Last <b>MARIE</b>	4. DATE OF DEATH <b>DECEMBER 22 nd 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1920</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>			
13. FATHER'S NAME <b>Sydney E. Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Moore</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mr. E. Carlyle Phillips (Husband) 133 Truitt St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Pulmonary + Cardiac metastasis</b> DUE TO <b>170X</b> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Carcinoma of left breast</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 mon</b> <b>15 mon</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>8.15</b>	(County) <b>12.22</b>	(State) <b>1956</b>
21. I certify that I attended the deceased from <b>8.15</b> , 19 <b>56</b> , to <b>12.22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>12.22</b> , 19 <b>57</b> , and that death occurred at <b>4:15 PM</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>H. E. Briele</i>	M.D.			ADDRESS (Street, city or town, state) Medical Center - Salisbury, Maryland		
PHYSICIAN'S NAME (Type) <b>Dr. Henry Briele</b>		DATE SIGNED <b>Dec. 23 /57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 24, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME * SALISBURY, MD.</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>DEC 27 1957</b>	24b. REGISTRAR'S SIGNATURE <i>Henry Holloway</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

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01-BRONX-IT ISN'T THE STATE THAT'S TO BLAME

BUREAU V.

DEC 27 1957

**RECEIVED**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13747

## CERTIFICATE OF DEATH

13769 332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
WICOMICO				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		MARYLAND	
SALISBURY		4 WEEKS		WORCESTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
SPRING HILL NURSING HOME				RURAL - POCOMOKE CITY	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
LOUISE				H. PILCHARD	DEC. 9 1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) IF UNDER 1 YEAR
FEMALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NOV. 3, 1879	78 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		—		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
CHARLES T. ARDIS		HARRIETT BONNEVILLE		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		231-46-3172		MRS. GEORGE WATERFIELD, POCOMOKE, MD.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Thrombosis		2 months	
332X		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				10-9, 1957, to 12-9, 1957	
21. I certify that I attended the deceased from 10-9, 1957, to 12-9, 1957, that I last saw the deceased alive on 12-9, 1957, and that death occurred at 3 PM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		Ellis J. M.D.		Salesbury, Md. 12-9-57	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
BURIAL		12-13-57		BAPTIST CEMETERY POCOMOKE CITY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Henry H. Watson		POCOMOKE, MD.		DEC. 16 1957	
				24b. REGISTRAR'S SIGNATURE	
				Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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RECEIVED STATE DEPARTMENT OF DEFENSE - DIA - 18

CERTIFICATE OF DEATH

WILSON

BUREAU V. S.

DEC 16 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG223 12-17-57 et  
13748 CERTIFICATE OF DEATH13770338  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA GENERAL HOSPITAL</i>		d. STREET ADDRESS <i>Baltimore Ave</i>	
3. NAME OF DECEASED (Type or print) <i>William A. Pitts</i>		Last <i>Pitts</i>	4. DATE OF DEATH <i>December 4 1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-14-1910</i>
9. AGE (In years last birthday) <i>47</i>		IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HABERER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>STORES</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Alex Bickhard</i>		14. MOTHER'S MAIDEN NAME <i>Clara Pitts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>579-14-7965</i>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerative Heart Disease</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>conclusion</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12-4</i> , 19 <i>57</i> , to <i>12-4</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12-4</i> , 19 <i>57</i> , and that death occurred at <i>6150A M</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>William Q. Ellis Jr.</i> M.D. PHYSICIAN'S NAME (Type) <i>Salisbury, Md.</i> ADDRESS (Street, city or town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>12-4-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIA</i>		22b. DATE THEREOF <i>12-8-1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>EVERGREEN Cemetery</i>
22d. LOCATION (City, town, or county) <i>BERLIN, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Stewart Funeral Home, Salisbury, Md.</i>		24d. REC'D BY REGISTRAR <i>REC'D 10 AM DECEMBER 10 1957</i>	24e. REGISTRAR'S SIGNATURE <i>Alary Wolloway</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEVADA—SERIAL NO. 18  
CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
DEC 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13749

## CERTIFICATE OF DEATH

1377B37  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Fruitland</b>		d. STREET ADDRESS <b>Main St</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen. Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>WILLARD</b>	Middle <b>LEONARD</b>	Last <b>FUSEY</b>	4. DATE OF DEATH <b>DECEMBER 29th 1957</b>	Month <b>Month</b>	Doy <b>Doy</b>	Year <b>Year</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 7, 1906</b>	9. AGE (In years last birthday) <b>51 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>		11. BIRTHPLACE (State or foreign country) <b>Princess Anne, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jefferson D. Pusey</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Heath</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Helen J. Pusey (Wife)</b>		Address <b>Fruitland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>416x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>491X Rheumatoid Arthritis</b>									
INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks.</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>MD.</b>		20f. (City or town) <b>3215 Div. St.</b>		(County) <b>Salisbury, Maryland</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from <b>Dec. 28, 1957</b> , to <b>12/29, 1957</b> , that I last saw the deceased alive on <b>12/28, 1957</b> , and that death occurred at <b>12:25 AM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Refus S. Gardner Jr.</b>									
ADDRESS (Street, city or town, state) <b>3215 Div. St., Salisbury, Maryland</b>									
DATE SIGNED <b>130 57</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 31, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>			
(State) <b>MD.</b>									
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. RECD BY REGISTRAR <b>JAN 3 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Mary W. Holloway</b>			

BUREAU V. 2

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REGELVÉD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13772337

13750

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>5½ years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Nellie</b>	Middle Lost <b>Putsche</b>	4. DATE OF DEATH Month <b>December</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/1872</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Putsche</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Manning</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arteriosclerosis</b>		Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1952</b> , to <b>December 11, 1957</b> , that I last saw the deceased alive on <b>Dec. 11, 1957</b> , and that death occurred at <b>4:25 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>	
ACTUAL SIGNATURE <b>L. V. Maldve,</b>		DATE SIGNED <b>12/12/57</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		M.D. Deer's Head State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 16, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME SALISBURY, MD.</b>		24a. REC'D. BY REGISTRAR <b>DEC 16 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF MARYLAND - BALTIMORE CITY  
CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
DEC 16 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13751

## CERTIFICATE OF DEATH

13773

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>13 months</b>		b. COUNTY <b>Cecil</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowinga</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>Marshall</b>	Middle <b>A.</b>	Last <b>Ragan</b>	4. DATE OF DEATH Month <b>Dec.</b>	Day <b>29</b>	Year <b>1957</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/1895</b>	9. AGE (In years lost birthday) <b>62</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME <b>Stephen Ragan</b>	14. MOTHER'S MAIDEN NAME <b>Mabel Alexander</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Hospital Records</b>	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO <b>422.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Degenerative heart disease</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumatoid arthritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <b>Nov. 13, 1956</b> , to <b>Dec. 29, 1957</b> , that I last saw the deceased alive on <b>Dec. 29, 1957</b> , and that death occurred at <b>11:05 P.M.</b> from the causes and on the date stated above.			ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE <b>Dr. V. Juerman</b>	M.D.	Deer's Head State Hospital	12/30/57.
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PHYSICIAN'S NAME (Type) <b>Dr. V. Juerman</b>	Salisbury, Maryland		
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22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jan 2 1958</b>	22b. DATE THEREOF <b>Jan 2 1958</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Pleasant Grove Pa., Bear Peach Bottom Pa.</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson, Rising Sun Md.</b>	ADDRESS <b>JAN 2 1958</b>	24a. REC'D BY REGISTRAR <b>Mary H. Holloway</b>	24b. REGISTRAR'S SIGNATURE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## WYOMING STATE DEPARTMENT OF HEALTH - SANITATION

## CERTIFICATE OF DEATH

FBI WIRELESS

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	60	M	CHLOROFORM
ADDRESS	STREET	CITY	STATE
100 E. 2ND	APT. 101	WYOMING CITY	WYOMING
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR		
DR. J. C. COOPER 100 E. 2ND	COOPER FUNERAL HOME 100 E. 2ND		
INVESTIGATOR'S SIGNATURE			
BUREAU V. R.			
RECEIVED JAN 2 1958			

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13774332  
Reg. Dist. No.

13752

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Mercer</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Saint Marys</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		d. STREET ADDRESS <i>West St.</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Florence</i>	Middle <i>B.</i>	Last <i>Royne</i>	4. DATE OF DEATH <i>December 12 1957</i>	Month <i>December</i>	Day <i>12</i>	Year <i>1957</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 27, 1885</i>	9. AGE (In years lost birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months <i>6</i>	IF UNDER 24 HRS. Days <i>9</i>	Hours <i>0</i>	Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PRACTICAL NURSE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>BERLIN MD RFD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>					
13. FATHER'S NAME <i>SEWELL DENNIS</i>		14. MOTHER'S MAIDEN NAME <i>SUSAN HOLLAND</i>		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS EUNICE FISITER</i>		BERLIN MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>159x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Adenocarcinoma, Hepatic.</i> DUE TO (c) <i>3) CARCINOMA, G-I TRACT(?)</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3WKS.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>321 S. DIVISION ST., SALISBURY MD</i>		20f. (City or town) <i>BERLIN</i>		(County) <i>MARYLAND</i>	(State) <i>M.D.</i>		
21. I certify that I attended the deceased from _____		11/28 1957		to 12/12 1957		that I last saw the deceased alive on _____		12/12 1957		and that death occurred at 11:22 AM, from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Rufus S. Gardner Jr.</i>		ADDRESS (Street, city or town, state) <i>321 S. DIVISION ST., SALISBURY MD</i>		DATE SIGNED <i>12/13/57</i>							
PHYSICIAN'S NAME (Type) <i>Rufus S. GARDNER, JR.</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/15/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>BUCKINGHAM</i>		22d. LOCATION (City, town, or county) <i>BERLIN</i>		(State) <i>M.D.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna D. Burbage</i>		ADDRESS <i>Berlin MD</i>		24a. RECD. BY REGISTRAR <i>DEC 16 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary J. Holloway</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PUREAU V. S.

DEC 16 1957

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13753 CERTIFICATE OF DEATH

13775337  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Nicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	c. LENGTH OF STAY IN lb	b. COUNTY <b>Maryland</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula GEN Hosp</b>	d. STREET ADDRESS <b>504 Collins St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer</b>	First <b>Elmer</b>	Middle <b>D.</b>	Last <b>Shockley</b>
4. DATE OF DEATH Month <b>12</b>	Month <b>12</b>	Day <b>12</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>A.A.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-4-1896</b>
9. AGE (In years last birthday) 61 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	11. KIND OF BUSINESS OR INDUSTRY <b>CHICKEN PLANT</b>	12. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>KATE Shockley</b>	14. MOTHER'S MAIDEN NAME <b>NORA Shockley</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. <b>244-10-9802</b>	17. INFORMANT <b>Elton Shockley - 504 Collins St, Salisbury, MD</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X</b> DUE TO Central Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) and (c) (b) DUE TO Cardio Vascular Renewal (c) Ischaemic Stroke	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Insulin Shock - Diabetes</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month Hour p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Salisbury</b>
(County) <b>Md.</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>Dec. 8, 1957</b> , to <b>Dec. 12, 1957</b> , that I last saw the deceased alive on <b>Dec. 12, 1957</b> , and that death occurred at <b>740</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Herbert Sembley</b>	PHYSICIAN'S NAME (Type) <b>G. Herbert Sembley</b>	ADDRESS (Street, city or town, state) <b>Salisbury Md 12/16/57</b>	DATE SIGNED <b>12/16/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12-16-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Harris Chapel Cemetery NEAR Snow Hill, Md.</b>	22d. LOCATION (City, town, or county) <b>Snow Hill, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Stewart Funeral Home, Salisbury, Md.</b>	ADDRESS <b>12/16/57</b>	24a. REC'D BY REGISTRAR <b>Mary J. Holloway</b>	24b. REGISTRAR'S SIGNATURE <b>12/16/57</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HIGHER EDUCATION

DEATH CERTIFICATE

BUREAU V. S.

DEC 19 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13754 CERTIFICATE OF DEATH

13776337  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b> <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>152 Upton St</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. STREET ADDRESS <b>152 Upton St</b>		d. STREET ADDRESS <b>152 Upton St</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNA BEULAH BENTON SMITH</b>	First <b>ANNA</b>	Middle <b>BEULAH</b>	Last <b>BENTON SMITH</b>
4. DATE OF DEATH <b>December 7 th 1957</b>	Month <b>December</b>	Day <b>7</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>May 4, 1866</b>
9. AGE (In years last birthday) <b>91</b>	10. IF UNDER 1 YEAR Months <b>91</b>	11. IF UNDER 24 HRS. Days <b>91</b>	12. IF UNDER 24 HRS. Hours <b>91</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad Clerk</b>	11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>George Robert Pollitt</b>	14. MOTHER'S MAIDEN NAME <b>Susan Amelia Moore</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Gordon Bennett (Daughter) 152 Upton St. Salisbury, Maryland</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Parsons Cemetery</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1957</b> to <b>12/7 1957</b> , that I last saw the deceased alive on <b>12/7/57</b> , 1957, and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b>	DATE SIGNED
ACTUAL SIGNATURE <b>Dr. Fred Cramse</b>	S. Division St. Salisbury, Maryland Dec 7 / 57		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 10, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>DEC 11 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>

BUREAU V. S.

DEC 11 1957

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13755

## CERTIFICATE OF DEATH

13755-32  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>		d. STREET ADDRESS <b>1702 Baker St</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION <b>PENINSULA General Hospital</b>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Ida</b>	Middle <b>Certrude</b>	Last <b>Smith</b>	4. DATE OF DEATH <b>December 8</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 3-</b>		9. AGE (In years lost birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work AT Home - None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Robert Prettyman</b>				14. MOTHER'S MAIDEN NAME <b>MARANDA Ellis</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. VAN Smith (Husband) Address Salisbury Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>Statis (Asthmaticus)</b>		<b>Bronchial Asthma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Obesity - Hypertension</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>ADDRESS (Street, city or town, state)</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while at work at work <b>at work</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Laurel Hill Cemetery Laurel Delaware</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>10 45 AM</b> , from the causes and on the date stated above. <b>ADDRESS (Street, city or town, state)</b>										DATE SIGNED	
ACTUAL SIGNATURE <b>Alberta Mattax</b>											
PHYSICIAN'S NAME (Type) <b>Alberta Mattax</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 12-1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Laurel Hill Cemetery Laurel Delaware</b>		22d. LOCATION (City, town, or county) <b>Laurel Delaware</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Holloway &amp; Co. Funeral Home-Salisbury Md.</b>		ADDRESS		24e. REC'D. BY REGISTRAR <b>DEC 11 1957</b>		24f. REGISTRAR'S SIGNATURE <b>Mary N. Holloway</b>					

AMERICAN FEDERATION OF NEARLY-DEAD

CERTIFICATE OF DEATH

RECEIVED

BUREAU V.

DEC 11 1957

RECEIVED

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH										Reg. Dist. No. 777		
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Westover</b>					b. COUNTY <b>Somerset</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private residence</b>					e. STREET ADDRESS <b>/</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Charles H. Speights</b>					First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-1863</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jerimiah T. Speights</b>					14. MOTHER'S MAIDEN NAME <b>Susan Tull</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>n/o</b>					16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>no</b>					17. INFORMANT <b>Mrs. Lawson F. Reichard</b> Address <b>Westover, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>Bundesal Panumina</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cardiac vascular renal disease</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Philip A. Insley</i> M.D. PHYSICIAN'S NAME (Type) <i>Philip A. Insley</i>										ADDRESS (Street, city or town, state) <i>Salisbury, Md</i> DATE SIGNED <i>12-24-1957</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-24-1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or county)		(State) <b>Princess Anne, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stein P. Wilson</i>					ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <i>Mary Holloway</i>			

81-39044-140-4-11240-30-3 ВМЛБРД ЭТАК ОНАДУА

BUREAU V. E.

EEC 30 1957

**REGEIYE**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13757

## CERTIFICATE OF DEATH

13757-331  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	c. LENGTH OF STAY IN lb 2 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville 17X02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)	First Walter	Middle Summers	4. DATE OF DEATH December 23 1957		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1893	9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Albert Summers		14. MOTHER'S MAIDEN NAME Lucy Watkins		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  177X		Ca. of prostate gland with generalized metastases		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO					
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ October 28 1957, to Dec. 23, 1957, that I last saw the deceased alive on Dec. 23, 1957, and that death occurred at 8:20 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. V. Juernman, M. D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/24/57	
PHYSICIAN'S NAME (Type)		Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORIAL Cenotaphical 93d	
22d. LOCATION (City, town, or county) Baltimore, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Decker West.		ADDRESS		24a. REC'D BY REGISTRAR DATE 1/2/58	
				24b. REGISTRAR'S SIGNATURE Mary Holloway	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
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87. BROWNSVILLE-INTERSTATE HIGHWAY STATE HIGHWAY

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8381 3 N7

REGELY 30

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13758

## CERTIFICATE OF DEATH

13780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Salisbury</u> <u>Wicomico County</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 10 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Maryland</u>		d. STREET ADDRESS <u>227 S. Queen Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Melissa</u>		First	Middle	Last <u>Thomas</u>	4. DATE OF DEATH <u>December</u>	Month <u>13</u>	Day <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1875</u>	9. AGE (In years last birthday) <u>82 yrs.</u>	IF UNDER 1 YEAR Months <u>7</u>	Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u>	Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chestertown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Hill</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Hill</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Hospital Records</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aortic stenosis and insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>			
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO <u>Hypertensive arteriosclerotic cardiovascular disease</u>				Unk			
		(c) DUE TO <u>General arteriosclerosis</u>				Unk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Salisbury, Maryland</u>		(County) <u>Wicomico County</u>	(State) <u>Maryland</u>
21. I certify that I attended the deceased from <u>Feb. 9, 1956</u> , to <u>Dec. 13, 1957</u> , that I last saw the deceased alive on <u>Dec 13, 1957</u> , and that death occurred at <u>8:50 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Gerhard Kosmahl</u>		M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>12/14/57</u>			
PHYSICIAN'S NAME (Type) <u>Gerhard Kosmahl, M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>James Cemetery</u>		22d. LOCATION (City, town, or county) <u>Chestertown</u>		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Waller</u>		ADDRESS <u>Chestertown, Maryland</u>		24a. REC'D BY REGISTRAR <u>12/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Holloway</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

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THE STATE OF NEW YORK - ALBANY

CERTIFICATE OF DEATH

BUREAU V.

DEC 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1813781

13774

## CERTIFICATE OF DEATH

Reg. Dist. No. 338

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown - Rural	c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural 09x22		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Shade Nursing Home		d. STREET ADDRESS Brookview		
3. NAME OF DECEASED (Type or print)	First Ida	Middle May	Last Wainwright	
4. DATE OF DEATH December	Month December	Day 10	Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1875	
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Corkran		14. MOTHER'S MAIDEN NAME Elizabeth Rhodes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT G. Garland Wainwright, Rhodesdale, Md., RFD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X Melanotic Sarcoma of neck DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ? 7		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month Dec. 19	Day 19	Year 1957	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sharptown, Maryland	(County) M.D.	(State) Maryland
21. I certify that I attended the deceased from Dec. 8, 1957, to Dec. 10, 1957, that I last saw the deceased alive on Dec. 9, 1957, and that death occurred at 2304 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharptown, Maryland DATE SIGNED 12-12-57				
ACTUAL SIGNATURE H. S. Kuhlman, M.D.		PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 12, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Brookview Cemetery	22d. LOCATION (City, town or county) Brookview, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DEC 16 1957	24b. REGISTRAR'S SIGNATURE Mary C. Owens	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ВГ ЗРОДИЛСЯ — ПІДАМ ВО СВІТОВІЙ СТАЦІОНАРІ

BUREAU V. S.  
RECEIVED  
DEC 16 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13759 CERTIFICATE OF DEATH										13782 Reg. Dist. No. 331		
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Delaware</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>					c. LENGTH OF STAY IN 1b <i>10 DAYS</i>					b. COUNTY <i>Sussex</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General Hospital</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Delmar</i>					d. STREET ADDRESS <i>RFD#2</i>		
3. NAME OF DECEASED (Type or print)		First <i>Ruth</i>	Middle <i>CATHERINE</i>	Last <i>Walter</i>	4. DATE OF DEATH Month <i>December</i>		Day <i>22</i>	Year <i>1957</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 1, 1914</i>		9. AGE (In years last birthday) <i>43</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>GEORGE W. GosLEE</i>					14. MOTHER'S MASTERNAME <i>ESSIE T. HATTON</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Wm L. WALTER, SAME</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>757.1</i>					DUE TO <i>Uremia</i>					INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Poly cystic Disease of Kidney</i>					(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Subarrachnoid Hemorrhage</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>224 N. Division St.</i>		20f. (City or town) (County) (State) <i>Salisbury, Md.</i>			
21. I certify that I attended the deceased from <i>Dec 11, 1957</i> , to <i>Dec 22, 1957</i> , that I last saw the deceased alive on <i>Dec 22, 1957</i> , and that death occurred at <i>6:30 P.M.</i> , from the causes and on the date stated above.					ADDRESS (Street, city or town, state) <i>224 N. Division St.</i>					DATE SIGNED		
ACTUAL SIGNATURE <i>Thomas C. Hill Jr.</i>					M.D.							
PHYSICIAN'S NAME (Type)												
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/27/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>HEBROW CEM.</i>			22d. LOCATION (City, town, or county) <i>HEBROW, MARYLAND</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hill Johnson Co. Salisbury, Md.</i>					ADDRESS <i>Norman T. Baker</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 30 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary Holloway</i>			

DEPARTMENT OF HEALTH - AGING HOME 18  
CERTIFICATE OF DEATH

BUREAU V.

DEC 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13760

## CERTIFICATE OF DEATH

13783

Reg. Dist. No.

337

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>7 mo. 6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dames Quarter</b>		d. STREET ADDRESS <b>1981-2</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>First Emma</b>		Middle <b> </b>		Last <b>White</b>		4. DATE OF DEATH <b>Dec. 8</b>	Month <b>Dec.</b>	Day <b>8</b>	Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Mar. 17, 1878</b>		9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months <b> </b>	IF UNDER 24 HRS. Days <b> </b>	Hours <b> </b>	Min. <b> </b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>Samuel Holland</b>				14. MOTHER'S MAIDEN NAME <b>Unk</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Salisbury, Maryland</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of rt. lung</b> DUE TO <b>163X</b>											INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b> </b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b> </b>		(County) <b> </b>		(State) <b> </b>		
21. I certify that I attended the deceased from <b>May 2, 1957</b> , to <b>Dec. 8, 1957</b> , that I last saw the deceased alive on <b>Dec. 8, 1957</b> , and that death occurred at <b>2:40 A.M.</b> from the causes and on the date stated above.											ADDRESS (Street, city or town, state) <b> </b>	DATE SIGNED <b>12/8/57</b>
ACTUAL SIGNATURE <b>N. Malde</b>		M.D. <b>L. Maldve, M.D.</b>		22d. LOCATION (City, town, or county) <b>Dames Quarter Maryland</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/18/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>macordogia</b>		22d. LOCATION (City, town, or county) <b>Dames Quarter Maryland</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>William H. Jones Jr. Funeral Home, Inc.</b>		ADDRESS <b>1000 W. Church Avenue, Inc.</b>		24a. REC'D BY REGISTRAR <b>REC'D 10/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>May Holloway</b>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and/or event within 72 hours after death.

CERTIFICATE OF DEATH

REGULAR STATE CERTIFICATE OF DEATH - FORM 16

RECEIVED  
BUREAU V. S.  
DEC 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13761 CERTIFICATE OF DEATH

13784

Reg. Dist. No.

332

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Minnie</b>	Middle <b>F.</b>	Last <b>White</b>	4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>15</b>	Year <b>19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6/16/1871</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>86</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Joshua Beathard</b>		14. MOTHER'S MAIDEN NAME <b>Martha Adkins</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ida White (Daughter-In-Law) Parsons- burg, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Arteriosclerotic cardiovascular disease</b>		Years							
DUE TO (b) <b>Arteriosclerosis, generalized</b>		Years							
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Old fracture of left femur</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Deer's Head State Hospital</b>		(County) <b>Wicomico</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>Dec. 11, 19 57</b> , to <b>Dec. 15, 19 57</b> , that I last saw the deceased alive on <b>Dec. 15, 19 57</b> , and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>12/16/57</b>									
ACTUAL SIGNATURE <b>L. V. Maldve</b>		M.D. <b>Deer's Head State Hospital</b> 12/16/57							
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsonsburg Cemetery</b>		22d. LOCATION (City, town, or county) <b>Parsonsburg, Maryland</b>		(State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		ADDRESS <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>DEC 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Holloway</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

RECEIVED  
DEPARTMENT OF HAWAII - SALINONE 18  
CERTIFICATE OF DEATH

BUREAU V. S.

DEC 19 1957

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the Board of Health.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH-DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13785

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethel</b> 461-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cor. of Locust Ter. &amp; W. Losuct St.</b>		d. STREET ADDRESS <b>R.D. #</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>NOLAN</b>	Middle <b>BRADFORD</b>	Last <b>WILLEY</b>	4. DATE OF DEATH	Month <b>December</b> Doy <b>1st</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 2nd, 1941</b>	9. AGE (In years at birthday) <b>16</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer on Farm</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chicken Grower</b>		11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>						
13. FATHER'S NAME <b>Bradford M. Willey</b>		14. MOTHER'S MAIDEN NAME <b>Marie O. Niblett</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Marie Taylor (Mother) Address Bethel Delaware</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>981X Bullet wound of Head</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>b</b>						
DUE TO <b>c</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Earl L. Royer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>December 2 1957</b>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 5, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>	ADDRESS	24a. REC'D. BY REGISTRAR <b>DEC 5</b>	24b. REGISTRAR'S SIGNATURE <b>1957 Mary Holloway</b>			
VS. A15ME SM 2/57						

RECEIVED  
FBI BUREAU

DEC 5 1957

BUREAU V. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 13776 CERTIFICATE OF DEATH

13786

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	<i>Wicomico</i>	STATE	<i>md</i>
CITY (If outside corporate limits, write RURAL OR give nearest town)	<i>MARYLAND</i>	CITY (If outside corporate limits, write RURAL and give nearest town)	<i>Wicomico</i>
TOWN	<i>Delmar</i>	STREET ADDRESS	<i>Delmar</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	<i>Halloway Nursing home</i>		
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
(First) <i>Nicodemus</i> (Middle) <i>Wilson</i> (Last)		12 25 1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>m</i>	<i>c</i>	<i>Wed</i>	<i>1867</i>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
<i>90</i>	<i>none</i>	<i>none</i>	<i>U.S.A</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<i>?</i>		<i>none</i>	<i>Lorraine Halloway</i>
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<i>420.0 IMMEDIATE CAUSE (A)</i>			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
<i>Arterio-sclerotic Heart Disease</i>			
INTERVAL BETWEEN ONSET AND DEATH			
<i>7 years?</i>			
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<i>Hypertension</i>			
<i>Mephritis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
<i>1 year</i>			
18. MEDICAL CERTIFICATION			
<i>Arterio-sclerosis</i>			
<i>Arterio sclerosis</i>			
<i>Hypertension</i>			
<i>Mephritis</i>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office-bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <i>Salisbury</i> (State) <i>MD</i>
21d. TIME OF INJURY (Month) <i>Dec</i> (Day) <i>27</i> (Year) <i>1957</i> (Hour) <i>12</i>	21e. INJURY OCCURRED M. While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Dec 9, 1957</i> , to <i>Dec 25, 1957</i> , that I last saw the deceased alive on <i>Dec 9, 1957</i> , and that death occurred at <i>12</i> M, from the causes and on the date stated above. SIGNATURE <i>L. Herbert Semblat</i> ADDRESS <i>Salisbury Rd</i> DATE SIGNED <i>12/23/57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>12-28-57</i>	<i>Union Cem</i>	<i>Delmar</i> <i>MD</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		
DATE <i>DEC 30 '57</i>	REGISTRAR'S SIGNATURE		
25. FUNERAL DIRECTOR'S SIGNATURE			
ADDRESS			
<i>Brooks McLean</i>			

STATE DEPARTMENT OF MARYLAND - BETHESDA

CERTIFICATE OF DEATH

DECEASED

BUREAU V.

DEC 30 1957

RECEIVED